



PLEASE READ INSTRUCTIONS ON REVERSE SIDE. PLEASE PRINT CLEARLY AND PRESS HARD WHEN WRITING

<div>2</div> <div>WHO SHOULD BE COVERED</div>	<div>3</div> <div>WAIVER OF COVERAGE</div>	<div>4</div> <div>TYPE OF CHANGE</div>
<div> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus Spouse <input type="checkbox"/> Employee Plus One Dependent <input type="checkbox"/> Employee Plus Child (ren) <input type="checkbox"/> Employee Plus Family </div>	<div> <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my dependents Reason: <input type="checkbox"/> covered under another plan <input type="checkbox"/> Other: _____ (see sections 6 & 7) </div>	<div> <div> <input type="checkbox"/> Add Spouse/Child (complete Sec. 5) <input type="checkbox"/> Reinstatement - Reason _____ </div> <div> <input type="checkbox"/> Terminate Spouse/Child (complete Sec. 5) <input type="checkbox"/> Surviving Spouse - Former EE SSN _____ </div> <div> <input type="checkbox"/> Address (enter above) <input type="checkbox"/> Name Change (complete Sec. 5) _____ </div> <div> <input type="checkbox"/> Terminate All Coverage - Reason _____ <input type="checkbox"/> COBRA Spouse - Former EE SSN _____ </div> </div>
<div> <p><i>*Note: If you are declining coverage for you or your dependents because of coverage under another health plan, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered a late enrollee if you enroll in this plan at a later date.</i></p> </div>		

COVERAGE INFORMATION									
(A) Add (T) Term (C) Chg	Last Name	First Name	MI	Social Security Number	Date of Birth	Gender	Other Medical Insurance	Disabled	Full-Time Student Over 19?
	Employee					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		
	Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		
	Child 1					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Child 2					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Child 3					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

6 OTHER INSURANCE		
<p>On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other medical plan or policy including another United Healthcare plan or Medicare?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is another person legally responsible for coverage for your children?<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you answered yes to either of the above questions, please complete the following:</p>		
Person's Name with Other Health Plan		Social Security Number
Date of Birth	Gender	Other Plan Name & Phone
Other Policy Number and Effective Date		
Medicare Number	Part A Effective Date	Part B Effective Date

7 AUTHORIZATION
<p>On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give United HealthCare and its affiliates (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim for any analytical or research purpose. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the Information provided is true and correct.</p> <p>If my employees plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at <i>any</i> time.</p> <p>NOTICE OF ENROLLMENT RIGHTS</p> <p>I understand that if I and/or my dependents, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after prior coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.</p> <p>X _____ Date _____</p>

TO BE COMPLETED BY EMPLOYER							
Date of Hire	Date Submitted	Health/Change Eff. Date	Policy Number	GRP/SUBGRP/BNFT GRP	Plan Variation/Sub	Rpt Code/Branch	ER Signature